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The Structural Model of Perfectionism Based on Childhood Trauma: The Mediating Role of Difficulties in Emotion Regulation Among Individuals with Obsessive-Compulsive Personality Disorder

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A B S T R A C T

This study examined a structural model in which difficulties in emotion regulation mediated the association between childhood trauma and perfectionism among individuals with OCPD. Methods: A cross-sectional descriptive-correlational design with structural equation modeling was used. The source population comprised individuals with a clinical diagnosis of OCPD who attended treatment centers in Khorramabad, Iran, during 2024-2025. A convenience sample of 196 participants completed the Multidimensional Perfectionism Scale, the Childhood Trauma Questionnaire, and the Difficulties in Emotion Regulation Scale. Descriptive statistics, correlations, measurement-quality indices, and structural paths were evaluated. Childhood trauma was positively correlated with emotion-regulation difficulties ($r=.234$, $p<.01$) and perfectionism ($r=.469$, $p<.01$), and emotion-regulation difficulties were positively correlated with perfectionism ($r=.354$, $p<.01$). Childhood trauma significantly predicted emotion-regulation difficulties ($\beta=.193$, $t=4.092$, $p=.001$) and perfectionism ($\beta=.160$, $t=3.962$, $p=.001$). Emotion-regulation difficulties also predicted perfectionism ($\beta=.375$, $t=7.650$, $p=.001$). The indirect effect of childhood trauma on perfectionism through emotion-regulation difficulties was significant ($\beta=.072$, $t=3.494$, $p=.001$), indicating partial mediation. Childhood trauma may be linked to perfectionistic tendencies in OCPD both directly and through impaired emotion regulation. Interventions that address trauma-related emotional processing and regulation may therefore be relevant when treating rigid perfectionism in this population.

Keywords: *childhood trauma; perfectionism; emotion regulation difficulties; obsessive-compulsive personality disorder; mediation; structural model.*

1. Introduction

Obsessive-compulsive personality disorder (OCPD) is a persistent pattern of personality functioning characterized by excessive concern with order, rules, control, productivity, and perfection, often at the cost of flexibility, efficiency, emotional openness, and interpersonal adaptation. Among these characteristics, perfectionism occupies a particularly central position because individuals with OCPD may establish excessively demanding standards, devote disproportionate attention to details, experience substantial difficulty accepting mistakes or incomplete

performance, and persist with rigid methods even when such strategies interfere with task completion or relationships. Consequently, perfectionism in OCPD cannot be regarded simply as conscientiousness or a preference for high achievement; rather, it may operate as a pervasive mode of self-regulation that structures how individuals evaluate themselves, respond to uncertainty, manage interpersonal expectations, and attempt to maintain control over their environments (Pinto et al., 2022; Redden et al., 2023). Clinical observations further indicate that perfectionistic functioning in OCPD is closely intertwined with severe self-criticism and rigid standards of personal adequacy, suggesting that the pursuit of flawlessness may become embedded within a broader system of maladaptive personality organization (Cheli et al., 2020).

Perfectionism itself is a multidimensional psychological construct, and an important distinction has been made between forms associated with relatively adaptive striving and forms characterized by maladaptive evaluative concerns. High personal standards may sometimes coexist with motivation, persistence, and achievement without producing substantial psychological impairment. However, perfectionism becomes increasingly maladaptive when self-worth becomes contingent on flawless performance, minor errors are interpreted as significant failures, standards are inflexible or unrealistic, and individuals engage in persistent self-criticism because their actual performance rarely corresponds to idealized expectations (Flett & Hewitt, 2020; Stoeber & Otto, 2006). From a clinical perspective, these maladaptive dimensions are especially consequential because perfectionism has been conceptualized as a transdiagnostic process implicated in the onset, persistence, and treatment resistance of multiple forms of psychopathology. Excessively rigid standards may generate recurrent discrepancies between actual and expected performance, which in turn intensify distress, repetitive evaluation, avoidance, procrastination, and attempts to regain control (Egan et al., 2011). Within OCPD, these processes may be particularly entrenched because perfectionistic standards are integrated into enduring personality patterns rather than occurring only in response to isolated situations.

The clinical significance of perfectionism in OCPD is reinforced by evidence showing that the disorder itself can substantially intensify perfectionistic tendencies. Individuals with OCPD may experience perfectionism not only as a cognitive preference but also as a persistent behavioral and interpersonal pattern that affects decision-making, work performance, emotional expression, relationships, and adaptation to changing circumstances. Evidence suggests that OCPD contributes meaningfully to the severity and expression of perfectionism, supporting the proposition that perfectionistic cognition and personality rigidity mutually reinforce one another (Redden et al., 2023). Moreover, the excessive self-monitoring associated with perfectionistic functioning can foster chronic tension between the desire to achieve ideal standards and the inability to tolerate perceived shortcomings. Clinical formulations of OCPD have therefore increasingly emphasized the interconnectedness of perfectionism, harsh self-criticism, emotional inhibition, and rigid control (Cheli et al., 2020; Pinto et al., 2022). Understanding the origins and mechanisms of this pattern is consequently important for identifying psychological processes that may be amenable to intervention.

One developmental factor that may contribute to the emergence of maladaptive perfectionism is childhood trauma. Childhood trauma encompasses adverse experiences such as emotional, physical, or sexual abuse, as well as emotional and physical neglect, all of which can influence the development of beliefs about the self, relationships, safety, and emotional experience. Children exposed to unpredictable, rejecting, punitive, or invalidating environments may learn that mistakes are dangerous, emotional expression invites criticism, and acceptance is conditional on compliance or successful performance. Under such conditions, the pursuit of perfection may gradually become a strategy for reducing perceived threat, obtaining approval, preventing rejection, or creating predictability. Although such strategies may initially function as attempts to adapt to adverse circumstances, they can become rigid and maladaptive when carried into adulthood. Empirical evidence supports the relationship between childhood trauma and maladaptive perfectionism, indicating that traumatic childhood experiences can contribute to perfectionistic tendencies directly and in conjunction with other psychological vulnerabilities (Dobos et al., 2021). More recent research also demonstrates that childhood trauma and perfectionism can interact in shaping stress, negative mood, feelings of defeat, and perceptions of entrapment, highlighting the continuing psychological consequences of the relationship between early adversity and perfectionistic functioning (O'Connor et al., 2026).

The developmental effects of childhood maltreatment extend beyond beliefs about performance and self-worth to the acquisition of emotional capacities. Emotional development occurs substantially through interactions with

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caregivers, through which children learn to identify affective states, interpret their meaning, tolerate distress, seek appropriate support, and employ strategies for modulating emotional arousal. Maltreatment can disrupt these developmental processes by exposing children to emotional environments characterized by fear, inconsistency, neglect, invalidation, or inadequate co-regulation. Longitudinal evidence indicates that patterns of childhood maltreatment are associated with subsequent differences in emotional processing and regulation during emerging adulthood, suggesting that early adversity may produce enduring vulnerabilities in the management of emotional experience (Warmingham et al., 2023). These effects are particularly important when maltreatment involves emotional abuse or neglect because such experiences directly communicate that emotions are unacceptable, unsafe, irrelevant, or likely to provoke adverse interpersonal consequences.

Contemporary evidence increasingly identifies difficulties in emotion regulation as a major mechanism through which childhood maltreatment becomes associated with adult psychological difficulties. A recent meta-analysis demonstrated consistent associations between childhood emotional abuse and multiple aspects of adult emotion regulation, indicating that early emotional maltreatment may have broad and persistent consequences for the capacity to understand, accept, and regulate affective states (Amini-Tehrani et al., 2026). Experimental evidence further suggests that people with histories of childhood maltreatment may demonstrate greater reliance on emotional suppression and reduced capacity to use cognitive reappraisal effectively, thereby limiting access to flexible strategies for managing emotionally demanding circumstances (Armbruster-Genc et al., 2025). These findings suggest that childhood trauma may leave a regulatory legacy whereby emotional states become difficult to tolerate or organize and are consequently managed through avoidance, inhibition, suppression, or rigid attempts to control internal and external conditions.

Emotion regulation refers broadly to the processes by which individuals monitor, interpret, accept, and modify emotional responses in accordance with situational demands and personally meaningful goals. Difficulties in emotion regulation may involve poor emotional awareness or clarity, nonacceptance of emotional responses, difficulty remaining goal-directed when distressed, impaired impulse control, and limited access to effective regulatory strategies. These difficulties are clinically important because they may transform ordinary negative emotions into prolonged or escalating distress. Individuals who experience emotions as confusing, uncontrollable, or unacceptable may attempt to compensate by exerting greater control over behavior, routines, standards, and environmental details. Accordingly, rigid perfectionistic behavior may partly serve as a strategy for organizing external circumstances when internal emotional states feel difficult to manage. Evidence across clinical populations supports the broad importance of emotion-regulation difficulties for psychological functioning (Razaghi et al., 2023), while developmental research increasingly suggests that such difficulties constitute a pathway through which childhood emotional maltreatment contributes to later psychopathology (Peter et al., 2026).

This pathway may be especially relevant in OCPD because the disorder is strongly characterized by overcontrol, inflexibility, and the pursuit of certainty. When an individual has difficulty identifying or tolerating emotional states, perfectionistic standards may provide a seemingly predictable framework through which distress can be managed. Strict rules can reduce ambiguity, exhaustive preparation can temporarily decrease anxiety about mistakes, and excessive attention to details can create a sense of control in circumstances that otherwise evoke emotional uncertainty. However, these strategies may also perpetuate maladaptive functioning by reducing opportunities to learn that mistakes, uncertainty, and emotional discomfort can be tolerated without catastrophic consequences. The result may be a self-reinforcing cycle in which emotional dysregulation encourages perfectionistic control, while failures to achieve perfection intensify self-criticism and further emotional distress. The clinical literature on OCPD supports the relevance of such an interaction between rigid perfectionism, self-critical cognition, restricted emotional experience, and maladaptive coping (Cheli et al., 2020; Pinto et al., 2022).

Additional evidence for the relevance of emotion regulation comes from research on obsessive-compulsive phenomena. Although OCPD and obsessive-compulsive disorder are diagnostically distinct, both may involve rigidity, repetitive control strategies, intolerance of uncertainty, heightened concern with errors, and difficulty flexibly responding to distressing internal experiences. A systematic review of the relationship between emotion-regulation difficulties and obsessive-compulsive disorder found consistent evidence linking obsessive-compulsive symptoms with maladaptive emotional processes, supporting the broader relevance of emotional dysregulation within obsessive-compulsive-spectrum presentations (See et

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al., 2022). Difficulties in emotion regulation have also been associated with symptom dimensions in individuals with obsessive-compulsive disorder, indicating that emotional dysregulation may be meaningfully related to the severity and expression of obsessive-compulsive psychopathology (Khosravani et al., 2020). Although these findings cannot be transferred directly to OCPD, they provide a compelling rationale for examining whether similar emotional mechanisms contribute to perfectionistic personality functioning.

The relationship between perfectionism and emotion dysregulation has likewise received increasing empirical attention. Maladaptive perfectionism is associated with an excessive focus on mistakes, self-evaluative threat, and difficulty disengaging from discrepancies between actual and ideal performance. These processes can generate intense negative affect, while inadequate regulatory capacity may increase reliance on rigid standards as an attempt to prevent future distress. Research examining maladaptive perfectionism and obsessive-compulsive behaviors has shown that emotion dysregulation can serve as an important intermediary mechanism, with self-compassion and emotional regulation helping to explain how maladaptive perfectionistic tendencies become associated with obsessive-compulsive behavioral patterns (Sher et al., 2024). Such findings are compatible with a model in which perfectionism is not merely an isolated personality characteristic but is dynamically connected to how individuals experience, interpret, and regulate difficult emotional states.

Taken together, these findings suggest a theoretically coherent developmental pathway from childhood trauma to difficulties in emotion regulation and subsequently to perfectionistic functioning. Exposure to childhood trauma may interfere with the development of stable self-worth and adaptive emotional regulation, increasing vulnerability to experiences of uncertainty, shame, threat, and perceived inadequacy. In response, rigid standards and perfectionistic control may become compensatory strategies designed to minimize errors, prevent criticism, secure interpersonal acceptance, or reduce emotionally threatening uncertainty. Evidence that childhood trauma and emotional dysregulation are jointly associated with perfectionism provides empirical support for this developmental account (Dobos et al., 2021), while contemporary research identifying emotion regulation as a mediator of the relationship between childhood maltreatment and adult psychopathology strengthens the plausibility of a mediational mechanism (Peter et al., 2026). The demonstrated association between childhood emotional abuse and adult emotion-regulation problems further suggests that regulatory difficulties may constitute one of the enduring psychological consequences through which adverse childhood experiences continue to influence adult personality and behavior (Amini-Tehrani et al., 2026).

At the same time, the proposed relationship should not imply that all perfectionism is inherently pathological or that childhood trauma necessarily produces perfectionistic personality functioning. Research on multidimensional perfectionism has consistently emphasized heterogeneity in the construct, with some forms of achievement striving being distinguishable from maladaptive concern over mistakes, social evaluation, and failure (Flett & Hewitt, 2020; Stoeber & Otto, 2006). What may be especially relevant to OCPD is not high standards alone, but their rigidity, their integration with self-worth, their resistance to contextual modification, and their use as mechanisms of control. This distinction also explains why perfectionism has transdiagnostic significance: similar rigid evaluative processes can interact with different vulnerabilities and contribute to diverse forms of psychopathology (Egan et al., 2011). In individuals with OCPD, the combination of early adversity, emotional dysregulation, and an enduring need for control may therefore provide a particularly important context for understanding how maladaptive perfectionism is maintained.

Despite growing evidence connecting childhood maltreatment with emotional dysregulation, emotional dysregulation with obsessive-compulsive phenomena, and childhood trauma with perfectionism, these relationships have more often been examined separately than within an integrated structural model focused specifically on individuals with OCPD. Existing evidence demonstrates that childhood maltreatment predicts enduring alterations in emotional processing (Armbruster-Genc et al., 2025; Warmingham et al., 2023), that emotional abuse is systematically associated with adult emotion-regulation difficulties (Amini-Tehrani et al., 2026), that emotion regulation may mediate the relationship between maltreatment and later psychopathology (Peter et al., 2026), and that perfectionism is closely connected with both childhood trauma and adverse psychological outcomes (Dobos et al., 2021; O'Connor et al., 2026). Research also establishes the importance of perfectionistic rigidity in OCPD and the relevance of emotional dysregulation to obsessive-compulsive-spectrum processes (Redden et al.,

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2023; See et al., 2022; Sher et al., 2024). However, the extent to which difficulties in emotion regulation account for the association between childhood trauma and perfectionism within a clinically relevant OCPD population remains insufficiently clarified.

Clarifying this mechanism has both theoretical and clinical importance. Demonstrating a mediating role for emotion-regulation difficulties would suggest that the association between childhood trauma and perfectionism is not solely attributable to enduring beliefs or direct effects of adverse experiences but may also operate through modifiable emotional processes. Such a perspective could broaden clinical formulations of perfectionism in OCPD beyond direct attempts to change rigid standards by incorporating assessment of developmental adversity, emotional awareness, acceptance of affective experience, distress tolerance, and flexible regulatory strategies. It would also support a more integrated conceptualization in which perfectionistic control is understood as part of an adaptive history that may have become maladaptive under later conditions. Given evidence that rigid perfectionism is functionally impairing in OCPD (Pinto et al., 2022), that emotion-regulation difficulties are relevant to obsessive-compulsive symptomatology (Khosravani et al., 2020; See et al., 2022), and that childhood maltreatment is associated with lasting regulatory difficulties (Amini-Tehrani et al., 2026; Warmingham et al., 2023), examining these variables simultaneously may help clarify a clinically meaningful developmental-emotional pathway.

Accordingly, the aim of the present study was to examine the structural relationship between childhood trauma and perfectionism and to determine the mediating role of difficulties in emotion regulation among individuals with obsessive-compulsive personality disorder.

2. Methods and Materials

2.1. Study Design and Participants

The study used a cross-sectional, descriptive-correlational design with structural equation modeling. The statistical population comprised individuals with a clinical diagnosis of obsessive-compulsive personality disorder who attended treatment centers in Khorramabad, Iran, during 2024-2025. A total of 196 participants were recruited by convenience sampling. The demographic data showed that 90 participants had a high-school diploma or lower, 59 had associate or bachelor's-level education, 33 had a master's degree, and 14 had doctoral-level education or higher. Regarding marital status, 175 participants were married and 21 were single.

Eligibility criteria were: (a) a clinical diagnosis of OCPD, (b) age between 23 and 50 years, (c) no reported alcohol or illicit-substance use, (d) willingness to participate, and (e) ability to read and write. Exclusion criteria were a history of psychiatric hospitalization and questionnaires judged to contain invalid or distorted responses.

2.2. Data Collection Tools

Multidimensional Perfectionism Scale (MPS). The 30-item multidimensional perfectionism measure developed by Hewitt and Flett assesses three domains: self-oriented perfectionism, other-oriented perfectionism, and socially prescribed perfectionism. The version described in the source study uses a five-point Likert response format. Higher total scores indicate stronger perfectionistic tendencies. The Persian version was previously standardized in Iran; the source document reports Cronbach's alpha coefficients of .90 and .80 for self-oriented and socially prescribed perfectionism, respectively, and test-retest coefficients of .85 and .84. In the current sample, the perfectionism construct showed Cronbach's alpha=.919, composite reliability=.929, and average variance extracted (AVE)=.522.

Childhood Trauma Questionnaire (CTQ). The CTQ was developed by Bernstein and colleagues as a retrospective screening measure of childhood maltreatment. It contains 28 items, of which 25 assess five core domains—emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect—and three items assess minimization/denial. Responses are scored on a five-point scale, with higher scores reflecting greater childhood trauma exposure. The total score ranges from 25 to 125. The source document reports an overall Cronbach's alpha of .85 for the measure. In the current sample, Cronbach's alpha was .956, composite reliability was .960, and AVE was .549.

Difficulties in Emotion Regulation Scale (DERS). The DERS was developed by Gratz and Roemer to assess clinically relevant difficulties in emotion regulation. The source document describes an initial 41-item pool and a 36-item scored form, consistent with the standard DERS scoring range of 36-180. Items are rated from 1 (almost never) to 5 (almost always). Higher scores indicate greater emotion-regulation difficulties. The scale yields a total score and six domains: nonacceptance of emotional responses, difficulties engaging in goal-directed behavior, impulse-control

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difficulties, lack of emotional awareness, limited access to emotion-regulation strategies, and lack of emotional clarity. Gratz and Roemer reported test-retest reliability of .88 and internal consistency of .93 for the total scale, with subscale alphas above .80. In the current sample, Cronbach's alpha was .953, composite reliability=.957, and AVE=.570.

2.3. Data Analysis

Descriptive statistics and preliminary data screening were conducted using SPSS version 26. The structural results reported in the source document are characteristic of partial least squares structural equation modeling (PLS-SEM), including composite reliability, AVE, HTMT, Q^2, RMS Theta, SRMR, and bootstrapped t statistics. Accordingly, the focal structural paths were interpreted within a PLS-SEM framework. Missing-data screening showed no missing observations. Collinearity was not problematic for the focal predictors (VIF values ranged from 1.014 to 1.329), and the Durbin-Watson statistic was 1.964. Although Kolmogorov-Smirnov and Shapiro-Wilk tests were significant, PLS-SEM does not require multivariate normality in the same way as covariance-based SEM. Statistical significance was evaluated at $p<.05$; bootstrapped path estimates were used for direct and indirect effects.

3. Findings and Results

The mean score for childhood trauma was 59.36 (SD=8.27), the mean score for difficulties in emotion regulation was 87.20 (SD=14.30), and the mean perfectionism score was 73.01 (SD=15.94). All three focal variables were positively and significantly correlated. Childhood trauma was correlated with emotion-regulation difficulties (r=.234, p<.01) and perfectionism (r=.469, p<.01), while emotion-regulation difficulties were correlated with perfectionism (r=.354, p<.01).

Table 1

Descriptive statistics for the focal study variables.

Variable	Minimum	Maximum	Mean	SD
Childhood trauma	25	125	59.36	8.27
Difficulties in emotion regulation	45	109	87.20	14.30
Perfectionism	30	150	73.01	15.94

Table 2

Pearson correlations among focal variables.

Variable	1	2	3
1. Childhood trauma	1		
2. Emotion-regulation difficulties	.234**	1	
3. Perfectionism	.469**	.354**	1

Internal consistency and convergent validity were satisfactory for all focal constructs. Cronbach's alpha and composite reliability values exceeded .90, and AVE values exceeded .50. HTMT values among the focal constructs were well below commonly used thresholds, supporting discriminant validity.

Table 3

Reliability and convergent validity indices.

Construct	Cronbach α	Composite reliability	AVE
Childhood trauma	.956	.960	.549
Emotion-regulation difficulties	.953	.957	.570
Perfectionism	.919	.929	.522

All three focal direct paths were statistically significant. Childhood trauma positively predicted difficulties in emotion regulation (β=.193, t=4.092, p=.001) and perfectionism (β=.160, t=3.962, p=.001). Difficulties in emotion regulation, in turn, positively predicted perfectionism (β=.375, t=7.650, p=.001). These findings

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indicate that greater childhood trauma exposure was associated with both greater emotion-regulation difficulties and stronger perfectionistic tendencies, while emotion dysregulation showed the largest focal direct association with perfectionism.

Table 4

Direct effects for the focal structural paths.

Structural path	β	Bootstrap mean	SD	t	p
Childhood trauma → Emotion-regulation difficulties	.193	.195	.047	4.092	.001
Childhood trauma → Perfectionism	.160	.161	.040	3.962	.001
Emotion-regulation difficulties → Perfectionism	.375	.372	.049	7.650	.001

The indirect effect of childhood trauma on perfectionism through difficulties in emotion regulation was significant (β=.072, t=3.494, p=.001). Because the direct path from childhood trauma to perfectionism remained significant after accounting for the mediator, the pattern supports partial mediation. Thus, childhood trauma was associated with perfectionism both directly and through greater difficulty regulating emotional experience.

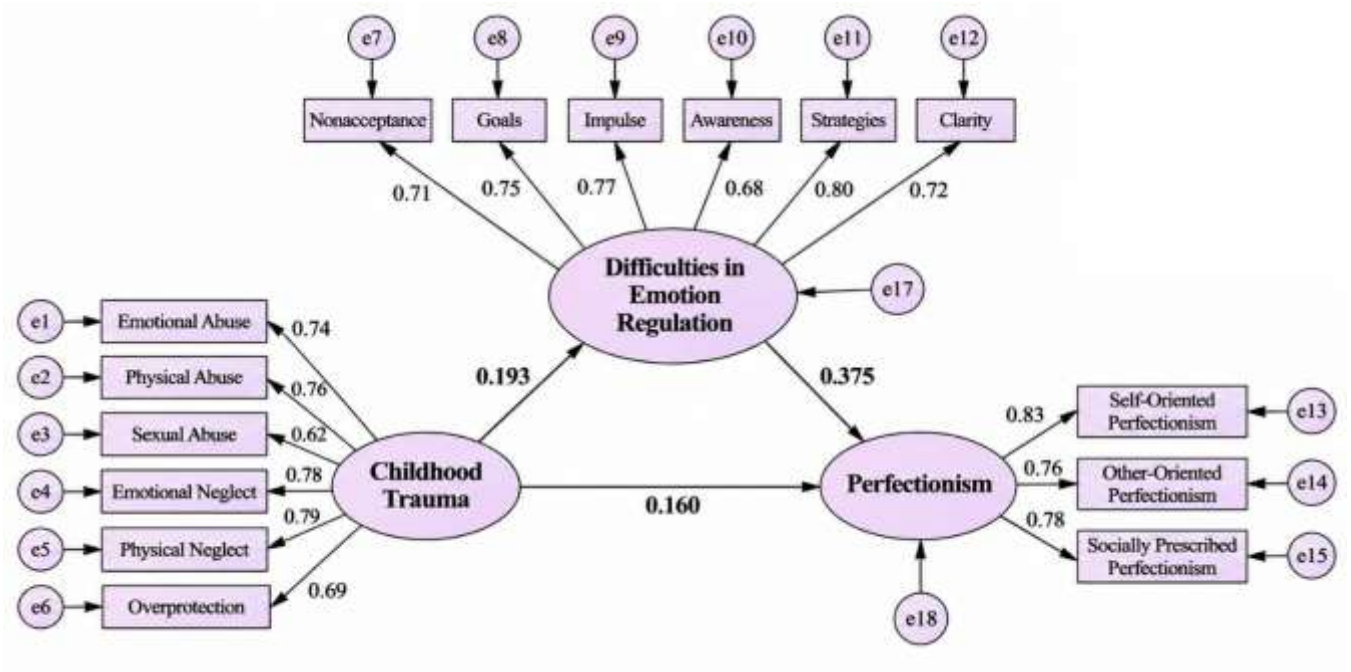
Table 5

Indirect effect of childhood trauma on perfectionism through emotion-regulation difficulties.

Indirect path	β	t	p	Interpretation
Childhood trauma → Emotion-regulation difficulties → Perfectionism	.072	3.494	.001	Significant partial mediation

Figure 1

Structural model of perfectionism with emotion regulation difficulties as a mediator



4. Discussion

The present study examined the structural relationship between childhood trauma and perfectionism among individuals with obsessive-compulsive personality disorder (OCPD), with particular attention to the mediating role of difficulties in emotion regulation. The findings supported the proposed conceptual model. Childhood trauma positively and significantly predicted difficulties in emotion

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regulation, childhood trauma also positively predicted perfectionism, and difficulties in emotion regulation positively predicted perfectionism. In addition, the indirect pathway from childhood trauma to perfectionism through difficulties in emotion regulation was statistically significant. Because the direct effect of childhood trauma on perfectionism remained significant after inclusion of the mediator, the findings supported partial rather than complete mediation. Taken together, the results suggest that childhood traumatic experiences may contribute to perfectionistic functioning in individuals with OCPD both directly and through their association with persistent difficulties in understanding, tolerating, and managing emotional experiences.

The first important finding was that childhood trauma significantly and positively predicted perfectionism. This result indicates that greater exposure to adverse childhood experiences was associated with stronger perfectionistic tendencies among individuals with OCPD. Such a finding is consistent with developmental perspectives suggesting that perfectionistic standards may emerge as compensatory strategies in response to environments characterized by criticism, unpredictability, conditional acceptance, emotional neglect, or excessive demands. In adverse developmental contexts, children may gradually learn that avoiding mistakes, meeting demanding expectations, and maintaining control are necessary for preserving safety or obtaining approval. When these beliefs become deeply internalized, they may continue into adulthood as rigid standards, excessive self-monitoring, fear of failure, and intolerance of imperfection. The present finding is consistent with the results of Dobos et al., who found that childhood trauma was positively associated with maladaptive perfectionism and that early traumatic experiences contributed to psychological processes underlying perfectionistic tendencies (Dobos et al., 2021). It is also compatible with evidence showing that childhood trauma and perfectionism jointly contribute to adverse psychological states such as stress, negative mood, defeat, and entrapment (O'Connor et al., 2026).

This association can also be understood in light of the multidimensional nature of perfectionism. Perfectionism does not simply reflect striving for excellence; maladaptive forms involve rigid standards, excessive concern over errors, self-critical evaluation, fear of negative judgment, and difficulty accepting performance that falls short of ideal expectations. Although some dimensions of perfectionistic striving can be relatively adaptive, maladaptive evaluative concerns are more consistently associated with psychopathology (Flett & Hewitt, 2020; Stoeber & Otto, 2006). Childhood environments marked by punishment, instability, neglect, or emotionally conditional relationships may foster precisely these maladaptive forms of perfectionism. Children may learn that mistakes have disproportionate consequences or that personal worth depends on flawless behavior. Over time, perfectionistic standards may become an internalized regulatory system aimed at minimizing the risk of rejection, criticism, shame, or loss of control. This interpretation is particularly relevant in OCPD, where rigid perfectionism is embedded within a broader personality pattern of control and inflexibility (Pinto et al., 2022; Redden et al., 2023).

The second major finding was that childhood trauma significantly predicted difficulties in emotion regulation. Individuals reporting greater childhood trauma also demonstrated greater problems in regulating emotional experiences. This result is strongly aligned with contemporary developmental and clinical evidence. Emotion-regulation abilities develop within early interpersonal relationships through processes such as emotional labeling, parental responsiveness, modeling, validation, and co-regulation. When these developmental environments are disrupted by abuse, neglect, rejection, or chronic unpredictability, children may have fewer opportunities to acquire effective strategies for identifying and modulating emotional states. As a result, they may become more likely to suppress emotions, avoid distressing internal experiences, experience low emotional clarity, or have difficulty maintaining goal-directed behavior during periods of emotional activation.

The present finding is consistent with evidence from Warmingham et al., who showed that patterns of childhood maltreatment predicted later differences in emotion processing and emotion regulation during emerging adulthood (Warmingham et al., 2023). Similarly, Armbruster-Genc et al. found that individuals with childhood maltreatment histories showed greater tendencies toward emotional suppression and poorer capacity for effective cognitive reappraisal, indicating that early maltreatment may have enduring consequences for the flexibility of emotional regulation (Armbruster-Genc et al., 2025). Particularly compelling support comes from the meta-analysis conducted by Amini-Tehrani et al., which demonstrated robust associations between childhood emotional abuse and difficulties across several domains of adult emotion regulation (Amini-Tehrani et al., 2026). The

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present findings therefore reinforce the view that emotion dysregulation may represent one of the principal psychological consequences through which childhood adversity continues to influence functioning in adulthood.

Peter et al. similarly provided evidence that emotion regulation operates as a mediating mechanism between childhood emotional maltreatment and adult psychopathology (Peter et al., 2026). This perspective is especially relevant to the current findings because childhood trauma may not simply produce isolated symptoms; instead, it may disrupt broader regulatory capacities that subsequently increase vulnerability to multiple maladaptive personality and behavioral patterns. Individuals who have learned to inhibit emotional expression, distrust internal experiences, or respond to emotional arousal with avoidance may increasingly rely on external control strategies. Within OCPD, this may involve rigid organization, excessive planning, overpreparation, adherence to strict rules, and perfectionistic standards. In this sense, perfectionistic control may partly serve as a substitute for insufficient emotional regulation.

The third major finding was that difficulties in emotion regulation significantly and positively predicted perfectionism. Indeed, emotion-regulation difficulties demonstrated the strongest focal direct association with perfectionism in the structural model. This suggests that individuals who have greater difficulty understanding, accepting, and regulating emotional experiences may be particularly likely to rely on perfectionistic rules and control strategies. When emotional states are perceived as unpredictable or threatening, rigid behavioral standards may provide a temporary sense of predictability and organization. For example, an individual who finds anxiety difficult to tolerate may attempt to eliminate uncertainty by excessive planning, repeated checking, or insistence that tasks be completed according to precise standards. Similarly, individuals who experience shame or self-criticism intensely may attempt to prevent these emotions by pursuing flawless performance.

This interpretation is consistent with the broader literature on perfectionism as a transdiagnostic process. Egan et al. emphasized that perfectionism may maintain psychopathology through rigid standards, repeated self-evaluation, fear of mistakes, and behavioral strategies designed to prevent perceived failure (Egan et al., 2011). When emotion-regulation capacity is limited, these processes may become even more rigid because perfectionism may function not only as a belief system but also as an emotional coping strategy. Clinical observations in OCPD similarly suggest that perfectionism, self-criticism, emotional restriction, and inflexible coping are interconnected rather than independent characteristics (Cheli et al., 2020). The current findings add empirical support to this perspective by demonstrating a significant structural relationship between emotion-regulation difficulties and perfectionism in individuals with OCPD.

Evidence from obsessive-compulsive-spectrum research also supports this result. See et al., in a systematic review, identified consistent associations between difficulties in emotion regulation and obsessive-compulsive disorder, including maladaptive emotional responses and reduced emotional acceptance (See et al., 2022). Khosravani et al. likewise showed that emotion-regulation difficulties were significantly related to symptom dimensions among patients with obsessive-compulsive disorder (Khosravani et al., 2020). Although OCD and OCPD are diagnostically distinct, both can involve rigidity, excessive control, intolerance of uncertainty, and maladaptive responses to distressing internal experiences. Therefore, the present findings may reflect a broader psychological process whereby ineffective emotional regulation increases reliance on repetitive or rigid strategies aimed at reducing uncertainty and distress.

The relationship between emotion dysregulation and maladaptive perfectionism is also consistent with the findings of Sher et al., who demonstrated that emotion dysregulation played a mediating role in the relationship between maladaptive perfectionism and obsessive-compulsive behaviors (Sher et al., 2024). Their findings suggest that perfectionistic concerns may become behaviorally consequential partly because individuals have difficulty regulating the emotional distress generated by perceived mistakes, incompleteness, or failure to meet standards. The present study extends this line of evidence by showing that, among individuals with OCPD, emotion-regulation difficulties are not only related to perfectionism but also constitute part of the pathway linking developmental adversity with perfectionistic personality functioning. The relationship is also consistent with findings demonstrating the broader clinical relevance of difficulties in emotion regulation across psychological disorders (Razaghi et al., 2023).

The most theoretically important result of the study was the significant indirect effect of childhood trauma on perfectionism through difficulties in emotion regulation. This finding indicates that part of the association between adverse childhood experiences and perfectionistic

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functioning can be explained by the long-term consequences of trauma for emotional regulation. Childhood trauma may interfere with the development of emotional awareness, acceptance, distress tolerance, and flexible strategy selection. In adulthood, individuals with these regulatory vulnerabilities may experience negative emotions as difficult to organize or control. Perfectionistic standards may subsequently emerge or persist as compensatory attempts to impose predictability and structure on both internal and external experience. This interpretation is strongly supported by Peter et al., who identified emotion regulation as an important mechanism linking childhood emotional maltreatment to adult psychopathology (Peter et al., 2026), as well as by Amini-Tehrani et al., who demonstrated substantial associations between childhood emotional abuse and later emotion-regulation problems (Amini-Tehrani et al., 2026).

The mediation was partial rather than complete, which is also theoretically meaningful. Difficulties in emotion regulation explain an important proportion of the relationship between childhood trauma and perfectionism, but they do not constitute the only mechanism involved. Childhood trauma may also contribute directly to perfectionistic functioning through maladaptive beliefs about personal worth, conditional acceptance, threat sensitivity, shame, fear of evaluation, or beliefs concerning the consequences of mistakes. Trauma may also influence attachment patterns, interpersonal trust, self-criticism, and perceived control, all of which could contribute to perfectionistic personality development. The direct effect remaining significant is therefore compatible with a multidetermined model of perfectionism in which emotional dysregulation represents one important mechanism among several possible developmental pathways. Such an interpretation is consistent with the multidimensional conceptualization of perfectionism and with evidence that perfectionistic functioning arises through the interaction of personality, developmental, cognitive, emotional, and interpersonal processes (Flett & Hewitt, 2020; Stoeber & Otto, 2006).

These findings are especially important in OCPD because perfectionism represents a core characteristic of the disorder rather than an incidental symptom. Research has demonstrated that OCPD contributes substantially to perfectionistic functioning and that excessive perfectionism may be associated with meaningful impairment in occupational, interpersonal, and emotional domains (Pinto et al., 2022; Redden et al., 2023). The current model suggests that some of this rigid perfectionistic functioning may be understood developmentally rather than solely as a stable personality trait. For individuals with histories of childhood trauma, perfectionistic rules may originally have provided a sense of safety, predictability, or control. However, when these strategies become inflexible and persist into adulthood, they may contribute to the characteristic rigidity and functional impairment associated with OCPD.

From a broader clinical perspective, the findings support conceptualizing perfectionism as a process with both developmental and emotional determinants. Treating perfectionistic behavior only by challenging demanding standards may therefore be insufficient when those standards are maintained by unresolved emotional vulnerabilities associated with early adversity. The findings suggest that understanding why rigid standards are needed may be as important as identifying what those standards are. If perfectionistic control serves to protect individuals from emotional uncertainty, shame, anxiety, or perceived failure, therapeutic change may require the development of alternative strategies for tolerating and regulating those internal experiences. This interpretation is compatible with evidence showing the intertwined nature of self-criticism and perfectionism in OCPD (Cheli et al., 2020) and with contemporary approaches that conceptualize perfectionism as a transdiagnostic maintaining process rather than merely a surface-level symptom (Egan et al., 2011).

Several limitations should be considered when interpreting the findings. First, the cross-sectional descriptive-correlational design prevents firm conclusions regarding temporal precedence or causality; therefore, the structural paths should be interpreted as theoretically consistent associations rather than evidence that childhood trauma causally produces emotion-regulation difficulties or perfectionism. Second, the study relied on retrospective self-report assessment of childhood trauma, which may be affected by memory bias, current mood, interpretation of past experiences, or response tendencies. Third, perfectionism and emotion-regulation difficulties were also assessed through self-report instruments, increasing the possibility of shared-method variance. Fourth, participants were recruited through convenience sampling from treatment centers in a single geographical area, which may limit generalizability to individuals with OCPD in other clinical, cultural, or community settings. Fifth, potentially relevant variables such as depressive and anxiety symptoms, attachment insecurity, shame, self-criticism, intolerance of uncertainty, or severity of personality pathology were not

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simultaneously examined and may partly account for the observed relationships. Finally, the significant partial mediation indicates that additional mechanisms are likely to contribute to the association between childhood trauma and perfectionism.

Future research should examine the proposed developmental pathway using longitudinal designs that can clarify the temporal sequence among childhood adversity, the development of emotion-regulation difficulties, and later perfectionistic personality functioning. Prospective studies beginning earlier in development would be particularly informative because they could reduce reliance on retrospective reporting and identify when perfectionistic control first emerges as a response to emotional vulnerability. Future studies should replicate the structural model in larger and more diverse clinical samples and compare individuals with OCPD with healthy controls and individuals with other personality or obsessive-compulsive-spectrum disorders. Multimethod assessment involving structured diagnostic interviews, clinician ratings, behavioral measures, ecological momentary assessment, and physiological indicators of emotional regulation would strengthen the validity of future findings. Researchers should also examine alternative or parallel mediators, including shame, self-criticism, attachment insecurity, intolerance of uncertainty, experiential avoidance, conditional self-worth, and maladaptive schemas. Testing moderated mediation models could further determine whether factors such as gender, trauma type, trauma severity, social support, or personality severity alter the strength of the identified pathways.

From a practical perspective, the findings suggest that clinicians working with individuals with OCPD and prominent perfectionistic characteristics should assess both developmental adversity and current emotion-regulation capacities rather than focusing exclusively on rigid standards and overt perfectionistic behaviors. Case formulation may benefit from identifying whether excessive planning, checking, overpreparation, self-criticism, and intolerance of mistakes serve regulatory functions such as reducing anxiety, shame, uncertainty, or emotional vulnerability. Intervention programs may incorporate emotional awareness, identification and labeling of affective states, acceptance of emotional experiences, distress tolerance, flexible reappraisal, reduction of emotional suppression and avoidance, and gradual exposure to uncertainty and imperfection. Trauma-informed therapeutic work may also help individuals understand the developmental origins of rigid control without reinforcing those strategies as necessary in current circumstances. Clinicians may therefore combine direct work on perfectionistic beliefs with strategies aimed at strengthening flexible emotional regulation, reducing harsh self-evaluation, increasing tolerance for mistakes, and developing more adaptive responses to situations that cannot be completely controlled.

Authors' Contributions

Authors equally contributed to this article.

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In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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